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# Assets in a community school health

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**Abstract**

Configuring a sixth stage in the historical evolution of health as a human right and socially determined poses the challenge of identifying the extent to which health assets model is known and capable of being implemented. In order to analyze this model in a learning community of Pamplona (Spain) adopted a qualitative participatory research design. From a sensitization session is conducted a focus group of 30 subjects and the information obtained is triangulated with the extracted three interviews. Triangulation of data allows assets to outline four dimensions of health: Perceived health, positive social values, lifestyle and positive relations.



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*Keywords:* school health, active in health, health promotion

## 1. Introduction

The definitions of health have evolved giving greater weight to various measures focused on healing, prevention or health promotion. We will take as its starting point the classification given by Gavidia distinguishes five stages of the historical evolution of western concept of health in the past century (Gavidia, 1998) : 1. Health as the opposite of the disease, 2. Health as being ideal (WHO, 1946) 3. Health as a balance with the environment (Dubos, 1967), 4. Health and lifestyle (Terris , 1980) and 5. Health and personal and social development (Lalonde, 1974).

Social dynamics and scientific advances are shaping new transformations in people and societies. The approaches of recent years can configure a sixth step of this historical evolution in which health is considered as a human right and socially determined (WHO, 2005). Emphasis is placed on health promotion and reflects a positive and inclusive concept of health as a determinant of quality of life, encompassing mental and spiritual wellbeing. The positive outlook on health and assets is one way of looking at health actions focused interest in the actions carried out by the individuals, families and communities to increase control and improve it. That look is what has led us to introduce the model of positive health to the people involved in this study: families, teachers and


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professionals linked to a health center primary education.

The proposal is that people can take care of your health by learning to make choices in their environment (Lindström and Eriksson, 2009). We define asset health as any factor or resource that enhances the ability of individuals, communities and populations to maintain health and well-being (Morgan and Ziglio, 2007). This concept of "active health " and " positive health " and seek to provide an accessible choice directed towards those aspects that facilitate health.

In this theoretical framework of education is one of the social determinants of major health and health education is one of the cornerstones for intervention in Public Health. The school, social services and health services, along with family and community, are the main sites and agents involved in the systematic development of Health Education (González de Haro , 2008). The educational style families, teachers and health professionals influence the acquisition of these skills for emotional, social development and academic achievement. Investigating the surrounding reality is the prelude to develop effective and interdisciplinary educational interventions through active community participation. Is the first step for new initiatives that promote active model. These are considered as a set of skills, talents and abilities that allow the choice of positive solutions. The result is a strengthening of self-confidence to meet the challenges of the environment (Hernán, Lineros and Morgan, 2010).

## 2. Research Objectives

Our purpose in this study raises two main issues: 1.Presentar model of health assets Lindström and Eriksson in a school community (families, teachers, health) in the city of Pamplona and 2.Analizar and identify the assets held in environment where the educational community that is contextualized.

## 3. Method

We propose a qualitative design of participatory action research.

### *3.1. Subjets*

Invited sample consisted of 30 subjects chosen intentionally (opinion sampling) to participate in Session awareness called " Assets in a school health education community " organized by the research group " Education and Health" Public University of Navarra (Pamplona, Spain ) . Participants belong to three groups linked to the school environment (ages 8-9 years): a) teachers, b) family c ) health professionals , their common features are :

- research experience in the area of health education in school
- collaboration on previous research
- highly motivated to participate in this project

In this sample, six participants chosen at random for the Group Discussion (GD) and three other than to carry out an in depth interview

Table 1 summarizes the three descriptive characteristics of the participating subjects, which are:

Table 1. Interviewed

| Group membership | Sex | Age |
|---|---|---|
| Family | F | 43 |
| Nurse | F | 38 |
| Teacher | M | 36 |

### *3.2. Techniques and Instruments*

A group interview by Group Discussion (GD) with six people, and technical community participation as one of the most suitable to explore the issue, according Botello (2012) is performed. Writing is used as the model school health assets Nordic (Lindström and Eriksson, 2009).

Subsequently held three individual semi-structured interviews whose script is made from two sources: 1) the same employee for GD and 2) a selection of relevant categories extracted Content Analysis of GD.

### *3.3. Procedure*

We have contacted the participants and confirm their attendance by mail. The awareness session of 2 hours, called " School Health Assets in a community," takes place in a classroom at the university for a moderate member of the research group. The group interview in GD is guided by an expert in group dynamics in a room videotaping of college, with duration of 90 minutes.

The three in-depth interviews are conducted by a researcher at the research group Education and Health in the same room of the group technique. The six open-ended questions are answered for 60 minutes each and are recorded on audio.

### *3.4. Analysis*

Analysis is performed content analysis of discourse with the NVIVO program identifying emerging categories and dimensions. The information provided in-depth interviews were triangulated with that obtained in the group interview.

## 4. Results

Results of the content analysis of the group interview (GD)

Opinions expressed by participants in the discussion group can extract categories that give rise to four dimensions of the Model Asset Health expressed by the subjects, which are: D1: Perceived health, D2: positive social values, D3: Style life and D4: positive relationships (Figure 1)

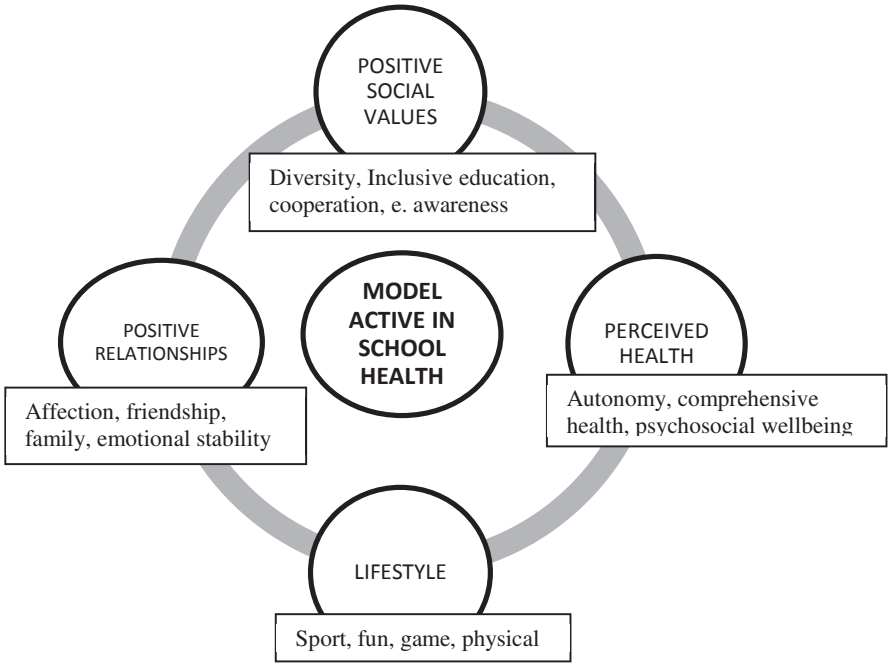


Fig. 1 Dimensions of the Assets in school health

Among the categories drawn from the group interview (GD), corresponding to D1 "Perceived Health" dimension are the following:

Table 2. D1: Dimension "Perceived Health"

| Categories | Description |
|---|---|
| D1c1 Autonomy | described as a requirement to take care of oneself and to achieve goals and life plans |
| D1c2 Comprehensive Health | defined from a holistic perspective |
| D1c3PsychosocialWellbeing | expressed in terms of personal and relational balance |

In the second dimension D2 "positive social values" categories included in Table 3 are explained:

Table 3. D2: Dimension “positive social values ”

| *Categories* | Description |
|---|---|
| *D2c1 Cooperation* | that promotes team spirit and solidarity-group |
| *D2c2 Diversity* | defined from a holistic perspective |
| *D2c3 Environmental awareness* | expressed in terms of personal and relational balance |
| *D2c4 Inclusive Education* | enhancing integration in school and in the community |

The third dimension D3: Healthy Lifestyle emerges from the reference to activities that promote attitudes and behaviors. They are described as key parts that need an interdisciplinary work among educators and health professionals from an early age. The categories are:

Table 4. D3: Dimension “Lifestyle”

| Categories | Description |
|---|---|
| D3c1 play | recreational activity to enjoy |
| D3c2 Physical Activity | body movement |
| D3c3 Sport | organization team that improves physical and mental condition. |
| D3c4 Fun | use of leisure time |

Finally, the categories include the fourth dimension D4: "Positive Relationships" are those that facilitate coexistence and self-esteem (Table 5)

Table 5. D3: Dimension "Positive Relationships"

| Categories | Description |
|---|---|
| D3c1 Emotional stability | factor of personality |
| D3c2 Affection | love and affection |
| D3c3 Friendship | affective relationship between staff |
| D3c4 Family | protection and security. |

From the identification of categories and dimensions performed a triangulation with the script used for the group interview (proposed by Lindström and Eriksson Model) and the following shall be prepared to conduct in-depth interviews.

Table 6 Script of in-depth interviews

| |
|---|
| 1. What do you understand by the concept of positive health? |
| 2 Do you know the model of health assets? |

| |
|---|
| 3. Which of health assets believed to contribute to the emotional well-being? |
| 4. What do you consider to be working in the school environment that promote positive social values? |
| 5. What active health promoting healthy habits? |
| 6. Is communication family / school / health center helps to improve the level of health? |

*4.1. GD Triangulation results and in-depth interviews*

Regarding D1: triangular When these data with the discourse of the interviews, we found that subjects interviewed point to a positive concept of health that goes beyond the absence of disease. Dimensions can be identified regarding the self-perception of their own health and sense of well- understood, feel healthy and develop the highest level of autonomy that allows you to perform everyday actions. Learn to care for themselves to achieve a psychophysical and social balance.

> *...Early Childhood Education from the concept of holistic health are working. Take care of my body and my mind I know my body and through him I relate to others. Being and feeling healthy...*

Regarding D2: Respondents familiar with the model of health assets. These assets are included in the transverse contents worked in the classroom.

> *The project-based learning allows children to experience in its immediate environment what we teach. They are the protagonists. Make presentations of their neighborhood, their places of entertainment your family ... and they show their behaviors . We try to avoid fragmented efforts and enable an overview...*

Among the weaknesses identified for implementation is the lack of projects coordinated school - health center.

Regarding D3: a match in the proper use of leisure time, outdoor play, use of public resources such as parks, libraries, interpretation is manifested. However reconciling work and family sometimes prevents developing such sedentary activities and favors the use of video games, television…

> *In the consultation we promote outdoor recreation, family activities ... there is movement. Usually families with economic difficulties and with little domestic time usually do not.*

A lack of teaching hours is evidence for the practice of Physical Education, recognized as active health.

The teachers themselves receives underestimation of this subject by parents as opposed to other academic content.

Regarding D4: There are references to values, perceptions, attitudes and behaviors of individuals. It is clear that personal behavior is largely determined by the life journey of each person, the process of socialization, education, by their experiences and the environment in which it is immersed. Some children because of their complicated life experiences usually start from a lower level from the emotional point of view. *...I see children with low self-esteem, little power of decision, so that they feel unappreciated...*

## 5. Discussion and conclusions

Identification of active health gives prominence to people in maintaining health. In this case a particular group, an educational community, select items and props that allow you to improve your wellness level. Similar research conducted in Western countries show the importance of a health asset mapping adapted to the context of each community (Lindström and Eriksson, 2009; Botello, 2012). In our study, the search field is the closest environment and actors actively involved in its discovery. However you need to include in the proposal schoolchildren themselves, something that must be taken into account in further investigations. Reading these results must be carried, thus from this consideration, not as a definitive result, but as a text open to revision and as a first step for future contributions.

The assets identified for describing dimensions of health from a multidimensional perspective including affectivity, social relationships, self-perception and lifestyle. Actually there is no absolute division between

dimensions, as all make up the whole person. The boundaries between areas are not clearly differentiated and are independent dimensions. Are interrelated, so that an improvement or worsening in any of them affects the health in schools.

The application of qualitative techniques is required in any assessment of experiences of Participatory Health Education (Morgan, D. 1998). Participation has a special meaning that may go unnoticed. Efforts to modify behavior change and generate positive health attitudes require a bidirectional character. The needs and demands of people for intervention are the first requirement to configure actions. Therefore we have tried to make their views known through a collective process of reflection and translate the values assigned in its qualitative dimension.

The very plasticity of school age possible to adopt lifestyles that mimic their families, teachers and other references. The closeness with students, teachers and families can know what is the paradigm of health education that is transmitted from the school. The health assets model is suitable for families and teachers are in their immediate environment, resources that may go unnoticed, and their discovery significantly contribute to maintaining and improving health.

Community participation in finding existing resources within the immediate environment to identify the most valued both individual and community aspects. Promotes positive choices and contributes to all to achieve the highest level of welfare.

## References

Botello, B., Palacio, S., García, M., Margolles, M., Fernández, F., Hernán, M., and Cofiño, R. (2013). Metodología para el mapeo de activos de salud en una comunidad. [Methodology for mapping assets in a community health]. *Gaceta Sanitaria*, 27 (2), 180-183

Gavidia, V. (1998). *Salud, educación y calidad de vida: De cómo las concepciones del profesorado inciden en la salud*. [Health, education and quality of life: How the teacher conceptions affect health] Santafé de Bogotá: Cooperativa Editorial Magisterio.

Dubos, R. (1967*). Man adapting*.York University Press: New York.

González de Haro, M.D. (2008). La educación para la salud: "asignatura pendiente " para la escuela. [The health education "pending" for school] *Revista de Educación XXI*, 10, 123-136.

Hernán, M., Lineros, C., Morgan, A. (2010). Los activos para la salud personales, familiares y comunitarios. Formación en salutogénesis y activos para la salud. Serie Monografías [Community assets for personal family health, and. Salutogenesis training and assets for health *Escuela Andaluza de Salud Pública* (EASP), 51: 15-27.

Lalonde, M. (1974).*A new perspective on the health of Canadians. A working document*. Ottawa: Government of Canada.

Lindström, B. and Eriksson, M. (2009). The salutogenic approach to the making of HiAP/healthy public policy: illustrates by a case study. *Global Health Promotion*, 1, 17.

Morgan, A., Davies, M., Ziglio, E. (2010). *Health Assets in a Global Context: Theory, Methods, Action*. New York: Springer.

Morgan, A., Ziglio ,E. (2007). Revitalising the evidence base for public health: an assets model. *Promotion & Education*,14,17-22.

Morgan, D. L.(1998) *Focus groups as qualitative research*. Newbury Park, CA, EE. UU. Sage 1998.

Terris, M. (1980) *La revolución epidemiológica y la Medicina social*[The epidemiological revolution and social medicine]Mexico: Siglo XXI

WHO (1946) Founding Charter. International Health Conference. New York.

WHO.(2005). Ministry of Public Health of Thailand. Bangkok Charter for Health Promotion in a Globalized World. Sixth World Conference on Health Promotion. Bangkok.